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Supreme Court of the United States

OCTOBER TERM, 1997

RANDON BRAGDON, D.M.D.,

Petitioner,

—v.—

SIDNEY ABBOTT, *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

BRIEF OF INFECTIOUS DISEASES SOCIETY OF AMERICA; NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS; ASSOCIATION OF STATE AND TERRITORIAL DENTAL DIRECTORS; AMERICAN ASSOCIATION OF DENTAL SCHOOLS; COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS; AMERICAN NURSES ASSOCIATION; ASSOCIATION OF NURSES IN AIDS CARE; NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS; AMERICAN PUBLIC HEALTH ASSOCIATION; ASSOCIATION OF REPRODUCTIVE HEALTH PROFESSIONALS; JOHN G. BARTLETT, M.D.; JAMES W. CURRAN, M.D., M.P.H.; JOHN C. FLETCHER, PH.D., M. DIV.; JUNE E. OSBORN, M.D.; MERLE A. SANDE, M.D.; BRIAN WISPELWEY, M.S., M.D. AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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INTEREST OF THE *AMICUS CURIAE*

This *amicus curiae* brief is submitted by the Infectious Diseases Society of America; National Alliance of State and Territorial AIDS Directors; Association of State and Territorial Dental Directors; American Association of Dental Schools; Council of State and Territorial Epidemiologists; American Nurses Association; Association of Nurses in AIDS Care; National Association of Public Hospitals and Health Systems; American Public Health Association; Association of Reproductive Health Professionals; John G. Bartlett, M.D.; James W. Curran, M.D., M.P.H.; John C. Fletcher, Ph.D., M. Div.; June E. Osborn, M.D.; Merle A. Sande, M.D.; Brian Wispelwey, M.S., M.D. ("Medical, Dental, Nursing and Public Health Professionals").[1] Medical, Dental, Nursing and Public Health Professionals play central roles in treating people with Human Immunodeficiency Virus ("HIV") disease and in protecting the public from the further spread of HIV and Acquired Immune Deficiency Syndrome ("AIDS"). The statements of interest of *amici* are included in the appendix to this brief.

This Court's rulings on the scope of the protections provided for those infected with HIV by the Americans with Disabilities Act ("ADA") will have a profound effect not only on individuals living with the virus, but also on public health efforts to combat the HIV epidemic. Medical, Dental, Nursing and Public Health Professionals have a central interest in ensuring that the Court understands the nature of HIV disease; how the virus is transmitted; and the threat which HIV discrimination, and the erosion of laws

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[1] This brief has been authored in its entirety by undersigned counsel for the *amici*. No person or entity, other than the named *amici* and their counsel, made any monetary contribution to the preparation or submission of this brief.

prohibiting it, pose to the public health as well as to the health of those infected with the virus.

By written consent of the parties,[2] *amici curiae* Medical, Dental, Nursing and Public Health Professionals submit this brief in support of Respondent Sidney Abbott.

SUMMARY OF ARGUMENT

The ADA prohibits discrimination against any individual with "a physical or mental impairment that substantially limits one or more of the major life activities of such individual." 42 U.S.C. § 12102(2) (1996). Infection with HIV meets this statutory definition.

HIV infection indisputably is an impairment. There is no period of time when the virus remains latent, and from the point of infection, HIV ravages the immune system and the ability to avoid disease. HIV also substantially limits major life activities of virtually every infected person. HIV is transmissible from infection until death, a fact which necessarily has a profound effect on human intimacy and procreative activities and which feeds the irrational fear and discrimination which confronts people who are infected.

A ruling by this Court that the ADA does not cover all persons with HIV infection would seriously undermine the nation's fight against the epidemic. A decision to deny protection to HIV-infected individuals who are without visible symptoms of disease, or who are unable to prove that they would have a child if uninfected, would be a powerful disincentive to get tested, seek medical attention, and secure the knowledge necessary to avoid infecting others. The pattern of discrimination against persons with HIV demonstrates that the unfounded fear of infection, not the

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[2] Letters of consent from all parties have been filed separately with the Clerk of the Court.

stage of disease, fosters discrimination; denial of protection for those in the earlier stages of HIV will legitimize, and likely increase, the too prevalent pattern of medical providers' refusals to treat those in need of care.

The argument that an HIV-infected patient poses a direct threat of infecting a dentist is completely at odds with scientific and medical knowledge. The risk of transmission of HIV in dental care is negligible, and all but eliminated by the consistent use of universal precautions which have been recommended by the Centers for Disease Control and Prevention and required by the Occupational Safety and Health Administration since the 1980's.

Judicial deference to the judgment of Petitioner, or any individual health care professional who refuses to treat patients with HIV because of concern that he might become infected, is unwarranted and in conflict with professional standards which treat such behavior as unethical. Deference to the unsupported opinion of an individual physician, dentist or other health care professional, rather than to the overwhelming consensus of public health officials charged with control of an epidemic, would jeopardize the public health and hinge the medical care access of those with HIV on the willingness of providers to overcome the irrational fear of a stigmatized disease.

ARGUMENT

I. FROM THE ONSET OF INFECTION, HIV IS A SERIOUS MEDICAL IMPAIRMENT.

HIV infection is a medical impairment. It always causes "loss or abnormality of psychological, physiological or anatomical structure or function." *Stedman's Concise Medical Dictionary for the Health Professions* 434 (3d ed. 1997). It is a remarkably complex retrovirus with a

"profound pathogenicity," i.e., ability to cause disease. Warner C. Greene, *Molecular Insights Into HIV-1 Infection,* in The Medical Management of AIDS 17, (Merle A. Sande & Paul A. Volberding eds., 5th ed. 1997). While the description of the earliest stage of HIV disease as "asymptomatic" is established in medical parlance, it is a construct to describe this stage rather than a medical reality.

From the outset, the virus targets those "T cells" (CD4+ helper T cell lymphocytes) which activate and regulate components of the immune system's response. Silvija I. Staprans & Mark B. Feinberg, *Natural History and Immunopathogenesis of HIV-1 Disease,* in The Medical Management of AIDS, *supra,* at 29, (5th ed.). The virus infects T cells, uses the cell's own genes to manufacture new viruses that infect other cells, and destroys increasing numbers of T cells in the process. Greene, *supra*; Staprans & Feinberg, *supra,* at 29. HIV targets those T cells which "may be the most essential in maintaining normal immune function," as well as cells which ingest pathogens and other harmful substances (bacteria, viruses and dead tissue). Staprans & Feinberg, *supra,* at 29. HIV triggers other disease processes not directly linked to immune system collapse, such as wasting (emaciation) and dementia. Department of Health and Human Services, National Institutes of Health, Report of the NIH Panel to Define Principles of Therapy of HIV Infection, at 18, (1997) [hereinafter "1997 NIH Panel Report"]; Greene, *supra,* at 19-20; Staprans & Feinberg, *supra,* at 34.

As noted recently by an expert panel convened by the National Institutes of Health:

> HIV infection is always harmful, and true long-term survival free of clinically significant immune dysfunction is unusual.
>
> ***

> ...Only about 2 percent or less of HIV-infected persons seem to be able to contain HIV replication to extremely low levels and maintain stable CD4+ T-cell counts within the normal range for lengthy periods ..., and many of these individuals display laboratory evidence of immune system damage.

1997 NIH Panel Report, *supra,* at 4 (reference omitted).

After the first signs of infection, a person who has tested HIV-positive[3] may be outwardly asymptomatic for years. However, the virus continues to spread throughout the body. "Although a period of clinical latency occurs in most individuals after acute infection, there is clearly not a period of virological or immunological latency." Sharon A. Riddler & John W. Mellors, *HIV-1 Viral Dynamics and Viral Load Measurement: Implications for Therapy*, in AIDS Clinical Review 1997/1998 47, 50 (Paul Volberding & Mark A. Jacobson eds., 1998). Recent studies conclusively demonstrated that the infected person hosts a very high level of continuous "virologic mayhem" -- daily and massive production of HIV virus, matched with massive destruction of T cells and generation of new cells attempting to replace them. Greene, *supra,* at 21; Riddler & Mellors, *supra,* at 49-50.

Even in patients who are in early stages of HIV disease, the virus is causing a wide variety of laboratory abnormalities, including anemia, platelet deficiencies, and other blood deficiencies. Margaret A. Fischl, *An Introduction to the Clinical Spectrum of AIDS,* in Textbook of AIDS

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[3] The commonly-used HIV tests detect antibodies for the virus in the individual's blood. When blood tests are positive for HIV antibodies, the individual has "seroconverted" and is termed HIV seropositive or HIV-positive. John Bartlett, Medical Management of HIV Infection, at 15 (1997 ed.).

Medicine 149, 150 (Samuel Broder et al. eds., 1994). Many patients suffer persistent dermatologic abnormalities, including scabies, psoriasis that is difficult to control, and a variety of bacterial and fungal infections. Michael S. Saag, *Clinical Spectrum of Human Immunodeficiency Virus Diseases,* in AIDS: Etiology, Diagnosis, Treatment and Prevention 203, 206 (Vincent T. DeVita et al. eds., 4th ed. 1997). Moreover, even outwardly asymptomatic patients are at increased risk for a number of potentially very serious medical conditions including mycobacterium tuberculosis, syphilis, acute and chronic hepatitis, toxoplasma gondii, and pneumocystis carinii pneumonia. Fischl, *supra*, at 150-51. In most infected persons, HIV infection progresses to severe immunodeficiency and AIDS[4] -- the "susceptibility to opportunistic infections, malignancies, neurologic diseases, and wasting, eventually leading to death." 1997 NIH Panel Report, *supra*, at 4.

II. FROM THE ONSET OF INFECTION, HIV SUBSTANTIALLY LIMITS A RANGE OF CENTRAL ACTIVITIES IN THE LIVES OF INFECTED INDIVIDUALS.

HIV profoundly alters the lives of those who are infected, forcing them to forego, or alter, several important life activities in a way that is profoundly different from that of persons without HIV-compromised immune systems.

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[4] Under Center for Disease Control and Prevention criteria, AIDS is diagnosed when a patient has one or more of a series of opportunistic infections or other diseases resulting from severe immunodeficiency, or when the patient's T cell count falls below 200 per cubic millimeter of blood (with normal T cell counts in the range of 1000). CDC, *1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults*, 41 MMWR RR-17 (1992).

Those infected with HIV must contend with the need to take precautions during every sexual encounter, and with the knowledge that the decision to bear a child risks transmission of a typically fatal illness to both the child and the other parent. Many must take medications in difficult regimens with often debilitating side effects. The need for proximity to medical professionals who treat HIV, and the inability to vaccinate against a number of potentially serious illnesses, limits travel and the ability to interact safely with others. The HIV-positive person also must live with chronic concerns about others' knowledge of his or her health status, social stigma and shame, the fear and reality of discrimination, and deep uncertainty about the future. Individually and in combination, these factors make it substantially more difficult for a person with HIV to care for himself and to take part in the full range of interactions with others, including sexual intimacy.

A. HIV Infection Substantially Interferes With The Ability to Care for Oneself.

Appropriate medical management of HIV disease includes all stages of disease, from initial infection through AIDS. Fischl, *supra*, at 149-58. It is important that patients with HIV infection "have their care optimized and disease progression slowed by a combination of monitoring, preventive therapy, and well-timed intervention with antiretroviral agents." Michael Clement & Harry Hollander, *Initial Evaluation of and Health Care Maintenance for the HIV-Infected Adult,* in The Medical Management of AIDS 130, 138 (Merle A. Sande & Paul A. Volberding, eds., 4th ed. 1995).

Physicians counsel patients with HIV infection to set their personal health care as a new priority in their lives. Lynda S. Doll & Beth A. Dillon, *Counseling Persons*

Seropositive for Human Immunodeficiency Virus Infection and Their Families, in AIDS: Etiology, Diagnosis, Treatment and Prevention, *supra*, 533, 534-38. In addition to medications typically prescribed to slow the progression of the disease, a physician will start the patient on prophylactic medications as immune system damage increases to prevent certain kinds of opportunistic infections, even if the patient is still relatively asymptomatic. Clement & Hollander, *supra*, at 109.

In 1996 and 1997, new antiretroviral therapies were approved by the Food and Drug Administration which, at least to date, are proving very effective in controlling disease progression in many patients. *See, e.g.*, Paul A. Volberding, *Protease Inhibitors Vindicated*, 350 Lancet SIII 10 (1997). The two major developments have been the introduction of new drugs, called protease inhibitors; and the adoption of "combination therapy" – the use of several antiretroviral drugs in combination. There are solid scientific reasons to believe that these combination therapies will benefit not only patients with more advanced HIV disease, but also many patients who are outwardly asymptomatic, and this therapy has been recommended for both. 1997 NIH Panel Report, *supra*, at 7; Steven F. Deeks & Paul A. Volberding, *HIV-1 Protease Inhibitors*, in AIDS Clinical Review 1997-1998 145, 174-75 (Paul A. Volberding & Mark A. Jacobson eds., 1998).

While the new therapies have saved lives, even after initiation of treatment the immune system does not completely recover, and significant damage caused by HIV likely is irreversible. Deeks & Volberding, *HIV-1 Protease Inhibitors, supra,* at 174-75. They also are burdensome, require substantial changes in each patient's diet and eating schedule, and typically require some scheduling accommodation in a range of settings, including work. These therapies "require[] strict adherence to complicated dosing regimens," Deeks & Volberding, *supra,* at 147. Because of

the danger of developing drug resistance, patients must strictly comply with the prescribed dosing regimen. 1997 NIH Panel Report, *supra*, at 12. The medications must be taken several times a day, usually at very specific intervals. Deeks & Volberding, *HIV-1 Protease Inhibitors, supra,* at 176. Some pills must be taken with high-calorie meals, some in a fasting state, and at least one requires aggressive hydration to prevent a build-up in the kidney. *Id.* Some of these medications require refrigeration, *id.*, which makes them more difficult to take at work and restricts activities away from home. Many patients find it impossible to comply with such a regimen for the rest of their lives, and as a result multiple drug resistance develops. Volberding, *Protease Inhibitors Vindicated, supra*, at SIII 10; *see* Deeks et al., *HIV-1 Protease Inhibitors*, J.A.M.A. 145, 152 (1997) (questioning whether "patients outside of a monitored research setting [can] comply with complicated regimens").

In addition, the medications commonly produce a number of side effects, sometimes very debilitating. Deeks & Volberding, *HIV-1 Protease Inhibitors, supra*, at 177. The side effects include severe nausea and abdominal pain, diarrhea, fatigue, weakness, anorexia, headaches, taste disturbances, and various laboratory abnormalities. *Id.*

Not only do many patients require some adjustment of work schedules in order to take medications under the prescribed conditions and to adjust to side effects, but the demanding nature of antiretroviral regimens may impose significant restrictions on a patient's ability to travel. HIV-positive persons must consider avoiding locations where there is not ready access to HIV medical expertise, and they cannot be immunized against several potentially deadly diseases.[5]

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[5] Vaccinations using live virus or bacteria are contraindicated for patients with HIV infection. Such vaccines include measles, mumps and rubella (MMR), varicella-zoster, BCG and yellow fever. Bartlett, *supra*

Although the new antiretroviral therapies are an exciting advance in HIV disease management, the virus has not been defeated, nor has HIV been transformed from a fatal to a manageable, chronic illness. Unfortunately, there also are significant numbers of patients for whom the new therapies do not appear to work or who develop resistance to these therapies. Deeks et al., *HIV-1 Protease Inhibitors*, *supra*, at 150-51; Volberding, *Protease Inhibitors Vindicated*, *supra*. Perhaps most important, these medications are too new for physicians to know whether the drugs will be effective in fighting disease progression in the long term. Deeks & Volberding, *HIV-1 Protease Inhibitors*, *supra*, at 179.

HIV threatens more than one's physical health, and many persons newly diagnosed with HIV suffer from severe emotional stress. Doll & Dillon, *supra*, at 534; Bartlett, *supra* n.2, at 213; Paul A. Volberding, *How to Tell Patients They Have HIV Disease*, in The AIDS Knowledge Base 2.6-1, 2.6-2 (P.T. Cohen et al., eds., 2nd ed. 1994). Multiple psychosocial stressors persist through all stages of their illness. Lisa Capaldini, *HIV Disease: Psychosocial Issues and Psychiatric Complications*, in The Medical Management of AIDS, *supra*, at 289, (4th ed.). One medical commentator describes this impact of HIV as follows:

> All patients with HIV disease, regardless of physical health status, face fundamental questions regarding the quality and length of their lives. Specific stressors experienced by HIV-positive people may include prolonged periods of physical discomfort, disability, and dependence, lifestyle disruption, loss of work and reduced socioeconomic status, disruption

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n.2, at 55-60.

> of support networks including family supports, decreased self-esteem, and sustained periods of loss of personal autonomy.

Id. at 296 (reference omitted). The depression and anxiety experienced by persons living with HIV often is exacerbated by medications that themselves cause depression and anxiety. *Id.*, at 296, 305. Medical care providers, including *amici*, who have cared for large numbers of persons with HIV disease frequently have seen the damaging effects of depression and anxiety, social stigma, and experiences of discrimination on their patients' health.

B. HIV Infection Substantially Limits Human Intimacy, Sexual Activity, Procreation and Parenting.

The HIV-positive person faces substantial and irreversible obstacles to all forms of intimacy. Most patients with HIV fear that disclosure of their condition will result in stigmatization, rejection by family, friends and co-workers, and discrimination. Doll & Dillon, *supra*, at 535. Stigmatization and discrimination are such important factors that the individual's primary physician or other health care provider are urged to "ask the patient who else knows of his or her seropositivity and review issues of confidentiality related to landlords, employers, insurance, and health care agencies." Laura A. Worth and Jeffrey H. Burack, *Outpatient Management of HIV Infection*, in The AIDS Knowledge Base 4.3-1, 4.3-19 (2nd ed.). Stigma and discrimination are a significant source of depression and anxiety in many patients, Doll & Dillon, *supra*, at 535, as is others' fear of infection, even through casual contact. The reality of HIV discrimination creates a painful dilemma for many HIV-infected persons. Most are understandably cautious about to

whom they disclose their diagnosis, but disclosure is necessary for the infected person to obtain health care and social support. *Id.* at 534.

A person with HIV lives with the reality that unprotected sex not only endangers his or her partner, but also may subject the patient to increased health risks if he or she is exposed to other diseases particularly dangerous for those with HIV, or contracts a new strain of the virus. Worth & Burack, *supra*, at 4.3-18.

Medical professionals often recommend that an infected person not engage in procreative sexual activity because an HIV-infected woman considering pregnancy and childbirth faces several additional risks. First, there is a significant risk that the virus will be transmitted from mother to child – while the child is in the womb, during labor or delivery, or through breast-feeding. Daniel V. Landers & Maureen T. Shannon, *Management of Pregnant Women With HIV Infection*, in The Medical Management of AIDS, 459, 461 (5th ed.). Even if the mother takes AZT during pregnancy and childbirth, in accord with current recommendations to reduce the possibility of HIV transmission to her child, the risk of transmission to the child is reduced only from approximately 25 percent to approximately eight percent. *Id.* at 462; Bartlett, *supra* n.2, at 68; Ann J. Melvin and Lisa M. Frankel, *Pediatric HIV Disease: New Developments in Treatment and Prevention,* in AIDS Clinical Review 1997/1998, 109, 112-13. Apart from the risk that the child might be infected, there is the real risk that the use of AZT monotherapy will produce drug-resistant virus that reduces the mother's own treatment options and that can be passed on to her newborn. Landers & Shannon, *supra*, at 459-61. Finally, uncertainty about their own life expectancy, and their reduced ability to care for themselves and their children, leads some women to decide not to conceive, or to abort when they learn they are pregnant and are HIV-positive. Doll & Dillon,

supra, at 536.

III. A RULING THAT ASYMPTOMATIC HIV INFECTED PERSONS ARE NOT PROTECTED UNDER THE ADA WOULD UNDERMINE PUBLIC HEALTH GOALS IMBEDDED IN THE ACT, BY DISCOURAGING ASYMPTOMATIC PERSONS FROM BEING TESTED, OBTAINING RISK-REDUCTION COUNSELING, AND OBTAINING ESSENTIAL MEDICAL TREATMENT.

In *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987), this Court recognized that legal protections against discrimination directed towards those with transmissible illnesses are vital to an effective public health policy in our democracy:

> [B]ecause the [Rehabilitation] Act requires employers to respond rationally to those handicapped by a contagious disease, the Act will assist local health officials by helping remove an important obstacle to preventing the spread of infectious diseases: the individual's reluctance to report his or her condition.

Id. at 286 n.15. This principle is particularly applicable to HIV. Antidiscrimination laws protecting all persons with HIV are critical to the nation's fight against the epidemic.

Voluntary HIV testing and counseling are key to controlling the spread of the disease. People who test HIV-positive routinely are counseled to avoid activities that pose a high risk of infecting others. Doll & Dillon, *supra*, at 536. "The earlier the infected person is detected, the earlier he or she may be advised of [his or her] contagious state and

counseled on how to avoid further transmission of this lethal virus." American Medical Association, *Prevention and Control of Acquired Immunodeficiency Syndrome: An Interim Report*, 258 JAMA 2097, 2102 (1987). Encouraging early awareness of HIV infection thus is critical to protecting public health.

Early detection of HIV disease also is critical to effective treatment. A patient's risk of developing many HIV-related opportunistic infections can be greatly reduced by prophylactic medications. As discussed in Part II.A, *supra*, many infected persons should be receiving antiretroviral therapy before they develop advanced HIV disease, and perhaps as soon as possible after infection.[6]

Fear of discrimination is a significant disincentive to undergo HIV testing and to seek medical care. The pervasive and powerful stigma associated with HIV and AIDS, and the justified fear of encountering discrimination, keep many persons from being tested to learn their HIV status. *The National AIDS Strategy* (Office of National AIDS Policy, Washington, D.C.), 1997, at 10, 23. Physicians, hospitals, public health agencies and community-based HIV/AIDS service organizations frequently encounter individuals who have delayed being tested for HIV, or who have delayed seeking medical treatment, counseling and other support services for months or years, because they fear discrimination.

Prior to enactment of the ADA, medical authorities pointed out the correlation between protections against HIV

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[6] Early medical intervention also is extraordinarily cost-effective, both for patients and for the public which must absorb the costs of care for uninsured, or publicly insured, individuals. "Just a few cents worth of medicine a day can prevent Pneumocystis carinii pneumonia, a disease that has catastrophic health consequences and costs." *Costs High for Failure to Get Treatment for PCP - Pneumocystis Carinii Pneumonia*, AIDS Weekly 10 (June 12, 1995).

discrimination and effective implementation of public health policy. A report of the Institute of Medicine of the National Academy of Sciences found that

> fear of discrimination is a major constraint to the wide public acceptance of many potentially effective public health measures. Public health programs will be most effective if they are accompanied by clear and strict sanctions to prevent unwarranted discrimination against those who are infected with HIV or who are at risk of infection.

Institute of Medicine, National Academy of Sciences, *Confronting AIDS: Directions for Public Health, Health Care, and Research: Update* 63 (1988). *See also 1987 AMA Report*, 258 JAMA at 2102 (1987) (American Medical Association report declaring that antidiscrimination laws should cover all HIV-positive persons to encourage HIV counseling and testing.)

In the legislative history of the ADA, Congress likewise observed that eradicating HIV discrimination has a significant public health dimension:

> As long as discrimination occurs, and no strong national policy with rapid and effective remedies against discrimination is established, individuals who are infected with HIV will be reluctant to come forward for testing, counseling, and care. This fear of potential discrimination ... will undermine our efforts to contain the HIV epidemic ....

H.R. Rep. No. 101-485, pt. 2, at 31 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 313 (quoting the 1988 Report of the

President's Commission on the Human Immunodeficiency Virus Epidemic). In testimony to Congress, Admiral James Watkins, Chair of the President's Commission, elaborated:

> HIV-related discrimination is impairing this nation's ability to limit the spread of the epidemic....Public health officials will not be able to gain the confidence and cooperation of infected individuals or those at risk for infection if such individuals fear that they will be unable to retain their jobs and their housing, and that they will be unable to obtain the medical and support services that they need because of discrimination based on a positive HIV antibody test.[7]

Petitioner and his *amici* argue that an HIV-positive person subjected to discrimination has no remedy under the ADA unless he or she has visible symptoms of HIV infection and can prove other substantial impacts in his or her own life. Any disability test excluding some individuals with HIV would create a ruinous incentive for people to avoid testing, counseling, and medical treatment.[8] The significance of

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[7] *Americans with Disabilities Act of 1988: Joint Hearing on S.2345 Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Human Resources and the Subcomm. on Select Education of the House Comm. on Education and Labor,* 100th Cong. 39-40 (1988) (statement of Adm. James Watkins), *reprinted in 2* House Comm. on Education and Labor, 100th Cong., 2d Sess., *Legislative History of Public Law 101-336, The Americans with Disabilities Act,* at 967-68 (1990).

[8] This reluctance to undergo testing probably would be exacerbated in jurisdictions requiring the reporting to public health authorities of positive HIV tests. Proponents of HIV names reporting base their position on the assumption that all persons testing positive are legally protected from discrimination. *E.g.,* Robert Steinbrook, *Battling*

potential discrimination to a decision to have an HIV test is so well recognized that some states require that individuals considering a test be explicitly informed of the risks of discrimination. *E.g.,*Conn. Gen. Stat. § 19a-582(d) (1997); Md. Regs. Code tit. 10, § 52.08.04 (1997); N.Y. Pub. Health § 2781(1) (Consol. 1997). In addition, as noted above (Part II. A), while antiretroviral therapies are recommended for many outwardly asymptomatic people, the decision to initiate therapy requires people with HIV to weigh the health benefits of treatment against the risk of possible discovery of their condition. Dosing requirements make combination therapy difficult for an employee who fears disclosure of her condition in the workplace, and health insurance claims also can alert the employer to a patient's health status. Once initiating therapy, an employee who varies a prescribed dosing regimen (to avoid revealing that he is on medication) risks developing drug-resistant virus.

Discrimination in health care is particularly damaging to efforts to combat the HIV epidemic. It not only results in denial of specific services, but also creates distrust of health care professions and institutions, and further fosters a reluctance by persons with HIV disease to seek medical care. After all, had Ms. Abbott not known, or volunteered, her HIV infection status, Dr. Bragdon would have filled her cavity, and this case would not now be before the Court. Given the importance of early diagnosis and treatment, and the fact that people with HIV experience discrimination as a consequence of unfounded fears about their infection rather than the stage of their illness, it is illogical and inconsistent with critical public health goals to base the protections against health care

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HIV on Many Fronts, 337 N. Engl. J. Med. 779 (1997); Lawrence Gostin et al., *National HIV Case Reporting for the United States – A Defining Moment in the History of the Epidemic,* 337 N. Engl. J. Med. 1162, 1165 (1997).

discrimination on whether symptoms of HIV disease are visible.

The ability of persons with HIV to rely on adequate dental care is important to maintaining their overall medical and psychological health. *Regular Dental Care Can Have Psychological and Physical Benefits*, AIDS Alert at 1 (Nov., 1993). HIV-positive patients generally have a greater incidence of complications from minor dental problems than those without HIV, and some untreated dental conditions can become sufficiently serious to interfere with health-related necessities of eating and taking medication. Michael Glick, *Intraoral Manifestations Associated With HIV Disease*, in *Dental Management of Patients with HIV* 153, 154-57 (Michael Glick ed., 1994).

The need for reliable quality health care, and the fear that this care will be denied, is a source of considerable anxiety for those who are HIV-positive. *E.g.*, Mauro A. Montoya, *If I Tell You, Will You Treat Me?*, 27 J. Marshall L. Rev. 363 (1994). As observed in a collaborative guide on public health, dental practice and HIV, "HIV-infected persons face sometimes insurmountable barriers...in finding health care providers willing to treat them." *Guide to Public Health Practice: HIV and the Dental Community* (Association of State and Territorial Dental Directors & Association of State and Territorial Health Officials, Washington, D.C.) (March, 1989) (J.A. at 125).

Several studies of dental professionals' attitudes conducted over the last decade suggest that patients' fears of discrimination are not unfounded. For example, in a 1991 study of dental students, 75% said that dentists have an obligation to treat patients with HIV, and 62% said that they would treat them in their own practices although 53% said that they would not treat patients with HIV if they had a choice. Eric S. Solomon, et al., *Issues in the Dental Care Management of Patients with Bloodborne Infectious*

Diseases: An Opinion Survey of Dental School Seniors, 55 J. Dental Educ. 594 (1991); Scott Burris, *Dental Discrimination Against the HIV-Infected: Empirical Data, Law and Public Policy*, 13 Yale J. on Reg. 1, 11-15 (1996) "*Dental Discrimination*"). Recent surveys still indicate both that a significant number of dentists are unwilling to treat patients who are HIV-positive, and that a significant number of persons with HIV encounter dental professionals who are unwilling to treat them. Burris, *Dental Discrimination*, *supra*, at 11-20.[9]

IV. THE RISK OF HIV INFECTION THROUGH DENTAL OR MEDICAL CARE IS

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[9] Lingering fears of patients with HIV, and consequent discrimination, has not been restricted to the dental profession. A survey of 951 neonatologists nation-wide found that many would withhold costly medical treatments from babies born to HIV-positive mothers, even if they had no idea whether the baby actually was infected with HIV. *In Brief...HIV Babies*, 10 AIDS Policy & Law 12 (1995). In the same study, a substantial number of doctors said that they would withhold life-saving treatment of babies even without confirmation of their actual serostatus. Only 25% stated that they would provide such care to babies known to be HIV infected. *Id.* Another survey of health professionals treating critically ill newborns at six New York City hospitals found that a significant number of those polled would be less likely to recommend aggressive treatment of a seriously ill infant with HIV than they would for a critically ill infant with no evidence of HIV exposure. Betty W. Levin et al., *Treatment Choices for Infants in the Neonatal Intensive Care Unit at Risk for AIDS*, 265 J.A.M.A. 2976, 2976-80 (1991). *See also* Ferdinand Christian, Jr. et al., *Open-Heart Surgery in an HIV-Positive Patient*, 10 AIDS Patient Care and STDs 210, 211 (1996) (discussing "a reluctance among surgeons and especially cardiothoracic surgeons to operate on HIV-positive patients"); C. Lewis & M.D. Montgomery, *Primary Care Physicians' Refusal to Care for Patients Infected with HIV*, 156 Western J. Med. 36 (1992) (almost half of those physicians surveyed reported an unwillingness to treat HIV-positive patients).

NEGLIGIBLE AND DOES NOT JUSTIFY A REFUSAL TO TREAT A PATIENT WITH HIV DISEASE.

The vehicles of HIV transmission have been well established since the mid-1980's: blood and blood products, semen, cervical and vaginal secretions, and breast milk. Staprans & Feinberg, *supra*, at 29. *See* Bartlett, *supra* n.2, at 2-3, 9-11 (giving breakdown of transmission routes). Dental workers face virtually no risk of acquiring HIV through occupational exposure to these bodily fluids. Despite the millions of dental procedures that have been performed since the first reported case of AIDS in 1981, there has been no documented case of occupational transmission of HIV to a dental worker. CDC, *Occupational Exposure to HIV, Information for Health-Care Workers* (visited January 25, 1998) <http://www.cdc.gov/ncidod/hip/faq.htm; Sara Babich, D.D.S. & Ronald P. Burakoff, D.M.D., *Occupational Hazards of Dentistry*, New York State Dental Journal 27, October 1997, at 26, 27.[10] Since the mid-1980's, seroprevalence surveys of dentists in selected cities and at American Dental Association annual meetings, and seroprevalence studies of dental assistants and dental hygienists in selected cities, have documented HIV infection rates of zero or almost zero. Ruthanne Marcus & David M.

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[10] *See also*, *Facts About AIDS for the Dental Team* (Council on Dental Therapeutics, American Dental Association, Chicago, Illinois), October 1988, at 5-6 *citing* N.M. Flynn et al., *Absence of Antibody Among Dental Professionals Exposed to Infected Patients*, 146 West. J. Med. 439 (1987) (255 dental workers with frequent HIV-positive patients, none HIV-positive), and Robert S. Klein et al., *Low Occupational Risk of Human Immunodeficiency Virus Infection Among Dental Professionals*, 318 N.Eng.J.Med. 86, 88 (1988)(1,309 dental workers, many practicing in areas with high prevalence of HIV infection, only one dentist tested positive but no occupational exposure to HIV could be documented).

Bell, *Occupational Risk of Human Immunodeficiency Virus Infection in Health Care Workers,* in AIDS: Etiology, Diagnosis, Treatment and Prevention, *supra,* at 645, 647-48.

Dentists, like other health care providers, are required to adhere to universal precautions for all patients to avoid exposure to bloodborne pathogens. The term "universal precautions" refers to a set of infection control practices under which health care workers assume that all blood and certain body fluids are potentially infectious and thus always take precautions to prevent direct exposure to these fluids. Universal precautions include basic barrier techniques (i.e. protective attire such as gloves, eyewear, masks, and gowns), careful handling of sharp instruments, safe disposal of all "sharps," use of surface disinfectants, and autoclaving or other methods of sterilizing instruments. Chris H. Miller, *Infection Control*, 40 Dental Clinics of North America 437, 439-54 (1996); CDC, *Recommended Infection-Control Practices for Dentistry*, 35 MMWR 237, 238-41 (1986); CDC, *Recommended Infection-Control Practices for Dentistry,* 1993 42 MMWR RR-8, 1, 3-9 (1993); OSHA, 29 C.F.R. § 1910.1030(d) (1997)(effective March 6, 1992). This is necessary because it is impossible to identify all patients who may be infectious. *See* Charles E. Barr, *Practical Considerations in the Treatment of the HIV-Infected Patient*, 38 Dental Clinics of North America 404, 420 (1994). Universal precautions can be easily and effectively implemented in the dental office.[11]

It is, therefore, inaccurate and misleading for *amicus*

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[11] A decade ago, the American Dental Association noted that patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed. *Facts about AIDS for the Dental Team*, *supra* n.10, at 15. It has reiterated this position to this Court. (Brf. *Amicus Curiae* American Dental Association in Supp. of Pet'r at 1-2 n.2.)

Promina to state that a 0.3% risk that a doctor or dentist caring for an HIV-positive patient will contract HIV. (Bragdon *Amicus Curiae* of Promina Northwest Health System in Supp. Of Pet's at 12-13.) The statistic Promina selected is: the risk of actual transmission to infected blood following percutaneous exposure (e.g., through accidental needlestick or laceration of the skin by another sharp object). Ruthanne Marcus & David M. Bell, *Occupational Risk, supra,* 645, 648; Barbara F. Gooch et al., *Percutaneous Exposures to HIV-Infected Blood Among Dental Workers Enrolled in the CDC Needlestick Study*, 126 J. Am. Dent. Ass'n 1237 (1997). In other words, there is a 99.7% probability that the unlikely occurrence of a needlestick or puncture wound, which delivers HIV-infected blood into the body, will *not* lead to infection. CDC, *Occupational Exposure to HIV, supra*. The overall risk faced by any doctor or dentist is very much smaller than 0.3%, since most health care providers never experience percutaneous injuries involving HIV-infected blood. Moreover, the estimated 0.3% risk *if* a health care worker suffers a needlestick or other puncture wound exposing him or her to HIV-infected blood is based on studies of all health care workers. The risk posed by a percutaneous injury to a dentist or other dental professional is much much smaller, and involve extremely small quantities of blood and minor injuries to the dental worker. Gooch, *supra,* at 1239-40.

Because universal precautions clearly work, the CDC unequivocally has stated that health care workers should not deny treatment to HIV-positive patients. CDC, *Recommendations for Prevention of HIV Transmission in Health-Care Settings*, 36 MMWR 2S, 15S (1987). Petitioner thus defies both well-established scientific evidence, and the findings and recommendations of our nation's leading public health officials, when he contends that dental care of an HIV-positive patient poses any significant risk to him.

V. THE ADA DOES NOT CONTEMPLATE JUDICIAL DEFERENCE TO A HEALTH CARE PROVIDER'S PERSONAL OPINION, UNSUBSTANTIATED BY OBJECTIVE EVIDENCE, THAT AN HIV-POSITIVE PATIENT IS UNSAFE TO TREAT.

Petitioner in effect seeks an exemption from his burden under the ADA to document the existence of a direct threat because of his professional status as a dentist. *Amicus curiae* Promina Northwest Health System similarly argues that "[h]ealth care service providers are unique and deserve special protection under the ADA." (Brf. *Amicus Curiae* of Promina Northwest Health System at 2.) Such an extraordinary level of deference to a defendant who has refused treatment on the basis of a patient's HIV status is inconsistent with the statute, with this Court's decision in *Arline*, and with the ethical standards of the dental and medical professions. There is no particular profession or level of training that automatically immunizes an individual from the prejudices that have long haunted the disabled and particularly those with infectious diseases, such as the plaintiff in *Arline* and the Respondent in this case.

Title III of the ADA covers, among many other types of public accommodations, "a...professional office of a health care provider [or] hospital." 42 U.S.C. § 12181 (7) (A). Nothing in the statute -- or this case -- requires that a health care institution or provider modify professional standards which govern their services. No health care professional is required to provide a patient with care that is medically inappropriate, outside the scope of the practitioner's area of competence, or that the practitioner would not provide to a patient without HIV.

However, when a provider denies services to a person with HIV because of fear of the risk posed by the person to

the provider or others, a single test for determining the legitimacy of the refusal applies to medical and non-medical providers alike. A "direct threat" exists if and only if the defendant proves "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices or procedures or by the provision of auxiliary aids or services." 42 U.S.C. § 12182(b)(3)(1996). This is an objective test; a finding of "direct threat" must be "based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence..." 28 C.F.R. § 36.208(c)(1997)(Department of Justice regulations). "Sources for medical knowledge include guidance from public health authorities, such as the U.S. Public Health Service, the Centers for Disease Control, and the National Institutes of Health, including the National Institute of Mental Health." *Id.* at, App.B. § 6.208(c). *Amici* concur with the court below that "properly supported opinions voiced by other recognized experts in the field (e.g., research studies published in peer-reviewed journals)" also are relevant. *Abbott v. Bragdon*, 107 F.3d 934, 945 (1st Cir. 1997).

The ADA's direct threat test, and the Justice Department's regulations, are based on this Court's rulings in *Arline*. After noting that persons with contagious diseases frequently have suffered from irrational fear and misapprehension, 480 U.S. at 284, the Court declared that, in adopting the Rehabilitation Act, Congress intended "to replace such reflexive reactions...with actions based on reasoned and medically sound judgment." *Id.* at 285. If "those accused of being contagious...never have the opportunity to have their condition evaluated in light of medical evidence...they would be vulnerable to discrimination on the basis of mythology -- precisely the type of injury Congress sought to avoid." *Id.* (footnote omitted). Therefore "courts normally should defer to the reasonable medical judgments of public health officials." *Id.* at 288 (footnote

omitted). This reasoning is entirely applicable to the Petitioner's reflexive reaction to HIV in this case, and particularly appropriate when the risk assessment involves possible transmission of contagious diseases -- both the area of expertise and the special responsibility of officials charged with protection of the public health. Nowhere in *Arline* does this Court suggest that deference is due to a doctor who is a defendant in a case challenging the discriminatory refusal to provide medical care, and who has a clear personal interest in the outcome of the litigation.

Since *Arline*, a number of lower federal courts have addressed cases of discrimination by health care professionals against persons with HIV or other disabilities. Those cases have recognized the need to distinguish bona fide medical opinion from pretext masquerading as medical judgment. In *Sumes v. Andres*, 938 F.Supp. 9 (D.D.C.1996), for example, an obstetrician refused to treat a hearing impaired pregnant woman with a fever, arguing that she was "high risk" and that he was not qualified to treat deaf people. The court held that "a provider may not withhold medical benefits solely based on a participant's disability, but may act only pursuant to a bona fide medical reason." *Id.* at 11.

Similarly, in a case challenging the denial of an ear operation for an HIV-positive patient, the court in *Glanz v. Vernick*, 756 F.Supp. 632, 638 (D.Mass. 1991) found that a rule affording initial deference to a defendant doctor's judgment in such circumstances would "enable doctors to offer merely pretextual medical opinions to cover up their discriminatory decisions." In *Howe v. Hull*, 873 F.Supp 72 (N.D. Ohio 1994), a man with AIDS sought emergency care at a local hospital, but the attending physician refused to admit him, claiming a suspicion that the plaintiff had a rare medical condition that they were not equipped to treat; the court found that this explanation was a pretext.

The claims of Petitioner and *amicus* Promina

Northwest Health System that health care professionals should be able to make their own decisions about risk, without following expert knowledge, are inconsistent with the nature of the dental and medical professions. A health care professional necessarily assumes a small degree of personal risk, *see* 107 F.3d at 948 ("a service provider like Dr. Bragdon is not entitled to demand absolute safety"), and dental and medical ethics recognize both that refusing care to HIV-positive patients is unethical, and that treatment of patients with HIV is not particularly risky:

> Since 1988, the Association has taken the specific position that refusal to treat a patient because that patient has or may have an infectious disease such as AIDS is unethical ... Education on universal precautions and barrier techniques is the most effective means to dispel unwarranted fears among health care professional and the public.[12]
>
> ***
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> A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive for HIV. Persons who are seropositive should not be subjected to discrimination based on fear or prejudice.[13]

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[12] *Position Paper on Acquired Immune Deficiency Syndrome* (American Association of Oral and Maxillofacial Surgeons, Rosemont, Illinois), Sept. 1991 (J.A. 111).

[13] *Code of Medical Ethics* (American Medical Association, Chicago, Illinois), 1996-1997 ed., § 9.131 (first issued in 1992). The AMA's Principles of Medical Ethics state that "when an epidemic prevails, a physician must continue his labors without regard to the risk to

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> Dental Health care workers have an ethical obligation to provide dental care to HIV-infected individuals, or those perceived to be at risk of HIV infection, in the same manner as they would to other patients . . . . HIV seropositivity is not sufficient cause for referral.[14]

It appears, however, that some health care providers equate prohibitions against discriminatory denial of care with an attempt of government to impose an affirmative obligation on providers to treat everyone who crosses their office threshold. As a committee of dental professionals observed in a practitioners' guide to AIDS & Dentistry:

> Some dentists are confused about the meaning of non-discrimination when it comes to the provision of dental care. It does not mean that the private practitioner has no choice regarding whom he or she chooses to treat. It does mean that there are some conditions upon which a practitioner may not base his or her treatment decisions.
>
> Dentists retain the right to refuse to take patients for a wide variety of reasons. Civil rights laws, however,

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his own health." *Ethical issues Involved in the Growing AIDS Crisis* (Council on Ethical and Judicial Affairs of the American Medical Association, Chicago, Illinois), Sept. 1988, at 1-2 *citing Principles of Medical Ethics* (American Medical Association, Chicago, Illinois), 1955.

[14] *Guide to Public Health Practice: HIV and the Dental Community* (Association of State and Territorial Dental Directors & Association of State and Territorial Health Officials, Washington, D.C.) (J.A. at 125-26).

> prohibit grounding that refusal upon the prospective patient's belonging to certain groups. No practitioner today would quarrel with the idea that it would be unethical as well as illegal to refuse to treat all blacks or all women. Similarly, AIDS civil rights law, specifically, and physical handicap rights laws, generally, prohibit practitioners from basing their care decisions upon the fear and prejudice which can be associated with physical handicaps, particularly contagious diseases.[15]

As noted in testimony on behalf of the American Dental Association to the President's Commission on the HIV epidemic on the issue of HIV-positive individuals' access to treatment:

> For the dental profession to respond in such a manner that "obligations to self-interest" override obligations to patients would be the beginning of the erosion of professional ethics and the trust that society has placed in the health professions. This trust is given legal sanction through the conferring of licenses to practice dentistry and moral sanction through the conferring of elevated status which dental and medical professionals enjoy in the community by reason of their special knowledge, skills and expertise.

Vincent C. Rogers, D.D.S., M.P.H., Testimony for the American Dental Association to The President's Commission

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[15] *AIDS & Dentistry, A Discussion Leader's Guide*, (Dental Steering Committee, AIDS Education and Training Center for Southern CA, Los Angeles, California) 1991 at 28.

on the HIV Epidemic (Jan. 14, 1988) at 5.[16]

Clearly then, while it is the opinion of *amici* here that the majority of health care workers respond professionally and skillfully in their treatment of HIV-positive patients, the provision of care to such patients, and interpretation of the ADA, cannot rest on the assumption that there will be sufficient accessible providers with "[c]ourage, conscience and calling," as Petitioner Bragdon's *amicus* Promina suggests (Br. *Amicus Curiae* of Promina Northwest Health System at 14), to allow care of the HIV-positive patient to remain the option of the individual provider. If one dentist or health care worker can deny treatment on "professional judgment" about risk of infection that runs counter to the overwhelming consensus of public health authorities, other medical experts, and professional ethical standards, then logically all may do so. A ruling that accommodates such judgments would virtually ensure that fewer health care providers will shoulder an increasing caseload of HIV-positive patients, and that significant numbers of men, women and children with HIV will forego the early medical intervention that reflects the standard of care necessary to

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[16] Indeed, in its *amicus* brief to this Court, the American Dental Association notes that its own ethical policies provide that "a decision not to provide treatment to an individual because the individual has AIDS or is HIV seropositive based solely on that fact, is unethical," and that "in Association communications on this issue, members be reminded that a patient's HIV/AIDS status is not a justification for refusal of treatment." *Amicus Curiae* Brief of the American Dental Association at 1-2 n.2. The American Dental Association argues, nonetheless, that the ADA should be interpreted not to cover all HIV-positive persons. Such an interpretation not only would be incorrect and harmful to the public health, but also would provide little if any meaningful guidance for dentists or other health care workers, who would be left not knowing when the ADA and similar laws govern their conduct and when they do not.

preserve health and stem further transmission.

Finally, creation of a "health care professional's exception" to the ADA in determining whether a particular patient poses a direct threat to the provider will have ramifications that extend beyond the health care needs of the affected individual patient. If a dentist or other health care provider is permitted to refuse treatment to persons with HIV or other infectious disease based on the provider's exaggerated fear of infection, communicable diseases of significant threat to the general public will go untreated and will pose an unnecessarily increased risk to the public.

CONCLUSION

For the reasons stated above, the Medical, Dental, Nursing and Public Health Professionals who have joined in this *amicus* brief respectfully submit that the decision below should be affirmed.

Respectfully submitted,

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APPENDIX

APPENDIX

The Infectious Diseases Society of America represents over 5,000 physicians, scientists and other health professionals dedicated to excellence in patient care, research and public health disease prevention and education in the field of infectious diseases. Infectious diseases is a board certified subspecialty of internal medicine and pediatrics. The majority of persons with AIDS in this country receive care from infectious diseases physicians.

The National Alliance of State and Territorial AIDS Directors (NASTAD) is the only national public health organization in the United States that focuses exclusively on the HIV/AIDS epidemic. Founded in 1992, the organization represents the chief HIV/AIDS program administrators in each state and territorial health departments who are responsible for managing federally-funded and state-funded HIV/AIDS prevention, health care and housing programs in every state. NASTAD members administer HIV prevention and surveillance programs funded by the Centers for Disease Control and Prevention. The organization's members also are responsible for administering programs which serve the medical care, AIDS drug assistance and supportive service needs of a significant number of the low-income, uninsured individuals with HIV/AIDS in the nation. NASTAD believes that discrimination against individuals with HIV infection represents a serious barrier to achieving federal, state and local goals in reducing the spread of HIV and in providing compassionate and effective health care services to individuals who are HIV-infected. As an organization, and as a collection of public health professionals focused on preventing the occurrence of HIV and providing health services to those who are infected, NASTAD is deeply concerned about the very real threat to the public's health

posed by discrimination against individuals with HIV infection.

The Association of State and Territorial Dental Directors (ASTDD) is a non-profit volunteer organization formed as an affiliate of the Association of State and Territorial Health Officers in 1948. ASTDD membership consists of the Chief Dental Public Health Officer of the State Health Department or equivalent public health agency, of the states, territories, or possessions of the United States. The purpose of this association is to consider policies and recommendations of public or private agencies pertaining to the practice of dental public health, which may impact the administration of dental public health programs at the state level, and to adopt policies for the guidance of its members. The ASTDD endorses the recommendations of the U.S. Public Health Service, the Centers for Disease Control and Prevention, and the Code of Ethics of the American Dental Association with respect to the treatment of HIV-positive patients in the private dental office.

American Association of Dental Schools (AADS) represents all 55 dental schools in the United States, as well as advanced education, hospital, and allied dental education institutions. It is within these institutions that future practitioners, educators, and researchers are trained; significant dental care provided; and the majority of dental research conducted. AADS is the only national organization that speaks exclusively for dental education.

Council of State and Territorial Epidemiologists (CSTE) is a professional association of 400 epidemiologists in U.S. states and territories working together to detect, prevent, and control conditions of public health significance. CSTE supports treatment by medical providers of HIV

infected persons and believes that routine dental care should not be denied to such patients. Universal precautions employed consistently are known to protect patients and health care workers, including dentists, form transmission of HIV. CSTE advocates that the public health interest is best served by intolerance of discriminatory refusals to treat HIV infected persons.

The American Nurses Association (ANA), a national labor and professional organization for registered nurses, consists of 53 state and territorial constituent organizations with approximately 180,000 members. The issue before this court directly involves not only the protection of individuals who are HIV-positive under the Americans with Disabilities Act (ADA) but has significant ramifications for the provision of early intervention and treatment of HIV. AMA has been at the forefront in advocating for the protection of patient confidentiality and in assuring all individuals full access to health care treatment.

Association of Nurses in AIDS Care (ANAC) is a national nursing organization committed to the individual and collective professional development of nurses involved in the delivery of care to persons infected or affected by the human immunodeficiency virus (HIV), and to promoting the health, welfare, and rights of all HIV-infected persons. ANAC recognizes that it is a moral, legal, and professional responsibility of nurses to care for persons with HIV infection.

National Association of Public Hospitals and Health Systems (NAPH) represents over 100 metropolitan area safety net hospitals and health systems nationwide. NAPH member institutions serve a large proportion of the nation's HIV/AIDS populations in both inpatient and outpatient

settings. In addition to providing medical care to persons with HIV and AIDS, NAPH has historically supported and advocated for the rights of these persons.

American Public Health Association (APHA) is a national organization devoted to the promotion and protection of personal and environmental health. Founded in 1872, APHA is the largest public health organization in the world, with over 50,000 members. It represents all disciplines and specialties in public health. APHA also publishes a technical report series dealing with various aspects of the HIV epidemic through the American Journal of Public Health, as well as numerous books related to HIV and state-of-the-art research.

Association of Reproductive Health Professionals (ARHP) is an interdisciplinary medical professional association composed of obstetricians/gynecologists and other physicians, advanced practice clinicians, researchers, educators, and other professionals in reproductive health. ARHP, founded in 1963, has an organizational mission to educate health care professionals and the public on family planning, contraception and other reproductive health issues including sexually transmitted diseases, HIV/AIDS, urogenital disorders, abortion, menopause, cancer prevention/detection, sexual health, and infertility. ARHP opposes restricting the ADA's anti-discrimination protections to those diagnosed with AIDS, and supports the principle that patient care should be a health care provider's primary concern.

John G. Bartlett, M.D., is Professor of Medicine and Chief of the Division of Infectious Diseases at the Johns Hopkins University School of Medicine in Baltimore, Maryland. Dr. Bartlett has authored over 600 medical articles

or chapters and eleven books including the principal physician handbook, Medical Management of HIV (in several editions, most recently 1997). Prior to joining the faculty at John Hopkins, Dr. Bartlett was a professor at the University of California and Tufts University School of Medicine.

James W. Curran, M.D., M.P.H., is Professor of Epidemiology and Dean of the Rollins School of Public Health of Emory University. Dr. Curran was the Coordinator for the Task Force on Kaposi's sarcoma (an AIDS-related cancer) beginning in 1981 and continued as a leader at the Centers for Disease Control and Prevention's (CDC) HIV/AIDS Division until 1995. He currently serves as the CDC liaison for the Association of Schools of Public Health, and chairs the Social Factors Reference subcommittee of the American Public Health Association Policy Committee.

John C. Fletcher, Ph.D., M. Div., was Emily Davie and Joseph S. Kornfeld Professor of Biomedical Ethics at the School of Medicine, and Director of the Center for Biomedical Ethics, University of Virginia, from 1987 until 1997. He also served as the Hospital Ethicist at the University of Virginia Health Services Center. Dr. Fletcher was Chief of the Bioethics Program at the Warren G. Magnuson Clinic Center, National institutes of Health, from 1977 to 1987. Dr. Fletcher has published extensively in medical ethics and bioethics, and is the author, with Dr. Brian Wispelwey, of *AIDS and Ethics* in Textbook of AIDS Medicine (Samuel Broder et al. Eds., 1st ed. 1994, 2d ed. 1998).

June E. Osborn, M.D., a pediatrician and a virologist, is the former Chair of the Congressional National Commission on AIDS (1989 to 1993) and of the World Health Organization's Global Commission on AIDS (1988 to

1992). Now Professor of Emerita at the University of Michigan School of Public health and Medical Schools, Dr. Osborn began working as a medical school faculty member in 1966, and became Dean of the School of Public Health at the University of Michigan from 1984 to 1993.

Merle A. Sande, M.D., holds and is Chairman of the Department of Internal Medicine, The Clarence M. and Ruth N. Birrer Presidential Endowed Chair in Internal Medicine, at the University of Utah. The author of more than 200 scholarly articles, Dr. Sande also is co-editor of the textbook, The Medical Management of AIDS (now in its fifth edition). An infectious disease specialist, Dr. Sande worked as Chief of Medical Services at San Francisco General Hospital when AIDS cases first appeared at the epidemic's beginning in the United States in the early 1980's through 1996.

Brian Wispelwey, M.S., M.D., is an Associate Professor of Internal Medicine (Infectious Diseases), at the University of Virginia in Charlottesville, Virginia, where he serves as the Director of the AIDS and Infectious Diseases Clinic at the University of Virginia Health AIDS Education Program for Health Care Providers, with Dr. Fletcher, Dr. Wispelwey co-authored *AIDS and Ethics* in Textbook of AIDS Medicine.